STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012450	A. BUILDING: _____ B. WING _____	11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CENTRE LLC	611 E DOUGLAS RD STE 108 MISHAWAKA, IN 46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for a standard licensure survey. Facility Number: 012450 Survey Date: 11/24/2014 & 11/25/2014 Surveyors: ReBecca Lair, LCSW Medical Surveyor Jacqueline Brown, RN Public Health Nurse Surveyor The Centre LLC is in compliance with 410 IAC 15.2, Ambulatory Surgery Center Licensure Rules. QA: claughlin 01/12/15	S 000		